TOTAL WELLNESS, LLC 7017 N Robinson Ave, Oklahoma City, OK 73116
CONSENT FOR TELEHEALTH AND RAPID TESTING SERVICES

Patient Name, Consenting Parent or Guardian _____
Date _____/_____/_____
I, _____ (Name of Patient, Consenting Parent or Guardian)
of_____ ("the patient"), after having received and considered (Patient, Consenting Parent or Guardian) information regarding the risks and benefits of telehealth and rapid testing services provided by Total Wellness LLC hereby authorize Total Wellness to provide the following health services to patient and/or Consenting Parent or Guardian patient who are not in the same physical location: Mark an "x" next to one or more of the health services you authorize:

- □ Telehealth visit with a Total Wellness practitioner
- □ Rapid COVID-19 test (nasal swab)
- □ Rapid flu test (nasal swab)
- □ Rapid strep test (throat swab)

By signing below, I understand the following:
The telehealth services will involve the delivery of healthcare services using two-way, real-time interactive video technologies between a Total Wellness practitioner and the patient, and/or Consenting Parent or Guardian patient who are not in the same physical location.

I will be given instructions about how to participate in the telehealth visit if I so choose. The Total Wellness onsite technician will administer a rapid COVID-19, flu, and/or strep test. The telehealth practitioner will provide the results during the telehealth visit.

Total Wellness will provide Patient, Consenting Parent or Guardian a summary of the health services provided to the patient, including information regarding exam findings, patient instructions, and any prescribed medications.

Total Wellness will collect the patient's insurance information from Patient, Consenting Parent or Guardian and will bill the insurance company for the health services provided to the patient.

Patient, Consenting Parent or Guardian must provide proof of Insurance prior to testing. Additionally, there may be patient discomfort associated with the nasal or throat swabs. The laws that protect privacy of medical information also apply to telehealth. The patient's privacy will be protected at all times and no information obtained through the use of telehealth will be disclosed to anyone else without patients written consent. The patient's participation in this service is totally voluntary, and I may decide to withhold or withdraw my consent at any time without affecting my right to future care or treatment. If the practitioner determines patient would be better served with face-to-face services or another form of care, patient will be referred to the nearest clinic, emergency room or other appropriate health care provider. A positive test result is an indication patient must self-isolate in an effort to avoid infecting others. I assume full responsibility to take appropriate action with regards to my test results. As with any medical test, there is the potential for a false positive or false negative test result. I understand and acknowledge that this service is provided by Total Wellness and I agree to hold harmless any other entity, its employees, representatives and agents from any loss or damage that may arise out of or relate to the healthcare services covered in this consent.

_____ _____/_____/_____
Signature of Patient. Date

BY SIGNING BELOW, I AUTHORIZE TOTAL WELLNESS TO PROVIDE THE ABOVE-SELECTED HEALTH SERVICES TO THE PATIENT WITHOUT MY PRESENCE. I FURTHER CERTIFY THAT I AM THE PATIENT'S SOLE CUSTODIAL PARENT, ONE OF PATIENT'S CUSTODIAL PARENTS, OR THE PATIENT'S COURT-APPOINTED LEGAL GUARDIAN AND THAT I HAVE LEGAL AUTHORITY TO CONSENT FOR ABOVE PATIENT.

Signing as: □ Parent □ Legal Guardian

_____ _____/_____/_____
Signature of Patient, Parent or Legal Guardian Date

**This consent shall be effective for the 2020-2021 school year.

Clinic Name: _____

Total Wellness Corporate Health

_____ LEVEL 1 No Provider (Standing Order)
_____ LEVEL 3 Provider Consult Via Telehealth
(see providers facesheet for Diagnosis Codes)

TeleHealth eVisit

Date: ____/____/_____

Name of Provider:_____

First Name (Legal)	MI	Last Name	Gender	
			Male	Female

Date of Birth	Email Address	Phone Number
/ /		( )

Home Address	City	State	Zip Code
		OK	

Race (check all that apply)		Ethnicity (check all that apply)	
☐ American Indian or Alaska Native	☐ Asian	☐ Hispanic or Latino	☐ Not Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander	☐ Black or African American	☐ Unknown	☐ Patient declines to respond
☐ White	☐ Other Race		
☐ Patient declines to respond			

Insurance Provider	Member ID Number	Group/Policy Number	Primary Insured DOB
			/ /

Vital Signs

Bio-Metrics			Chief Complaint and for how long:	Allergies
Weight:		BP-Systolic:		
Height:		BP-Diastolic:		
Temp		Pulse (BPM):		
		O2 Saturation:		

Current Medications:

Medical Evaluation (Please circle one)

Do you feel Achy?	Yes or No	How severe on 1-10 scale. 10 is worst.	1 2 3 4 5 6 7 8 9 10
Do you have a cough?	Yes or No	Do you have Nasal Congestion?	Yes or No
Is it productive? If yes, describe	Y or N / Dry ☐ Productive ☐	Nature of Sputum or cough if productive?	Clear ☐ Yellow/Green ☐ White ☐ Thick ☐ Bloody ☐
Do you have a runny nose?	Yes or No		
Do you have any sinus pain?	Yes or No	If Yes, how severe on 1-10 scale. 10 is worst.	1 2 3 4 5 6 7 8 9 10
Do you have post nasal drip?	Yes or No	Do you have a sore throat?	Yes or No
Do you have ear pain?	Yes or No	If yes, which ear?	Left ☐ Right ☐ Both ☐
Do you have asthma?	Yes or No	If yes, do you use an inhaler? If yes, how often?	Yes or No
Do you have diarrhea?	Yes or No	Have you vomited in the last 12 Hours?	Yes or No
Does your scalp itch?	Yes or No	Do you have any rashes?	Yes or No
Are your eyes having allergic reactions? Please describe	None ☐ Right ☐ Left ☐ Both ☐ Red ☐ Watery ☐ Itchy ☐		
Have you been exposed to Covid-19?	Yes or No	If yes, when?	
Have you been exposed to Flu?	Yes or No	If yes, when?	
Do you use tobacco?	Yes or No	If yes, what type?	
Do you vape?	Yes or No	If yes, how often?	
What medicines have you tried? Please include herbal vitamins and over the counter.		Was there improvement?	

Testing Completed

Time Collected:_____Med. Staff_____ Time Tested:_____Med. Staff_____	Results Covid-19 Negative Positive
Time Collected:_____Med. Staff_____ Time Tested:_____Med. Staff_____	Results Flu Negative Positive
Time Collected:_____Med. Staff_____ Time Tested:_____Med. Staff_____	Results Strep Negative Positive

Medical Staff Notes:

Total Wellness Corporate Health
Oklahoma City Office 7017 N. Robinson Ave.
Oklahoma City, OK 73116
Tulsa Office 6526 E 60th St.
Tulsa, OK 74145

2021 HIPAA Release Form

Section 1

Part 1: Self-Assessment	
Do ANY of the following apply to you?	
1. Have symptoms of acute respiratory illness or fever (100.4° F [37.8° C] or greater using an oral thermometer) without the use of fever-reducing or other symptom-altering medicines (e.g., cough suppressants).	YES/NO
2. Patients with COVID-19 have reportedly had mild to severe respiratory illness. Have you had any Symptoms that include:headache, cough, sore throat, difficulty breathing, chest pain, muscle pain, fatigue, or chills	YES/NO
3.Within the last 14 days, you have had "close contact" with someone with COVID-19? Close contact is defined as: a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)	YES/NO

By signing this document, I understand that I have voluntarily agreed to this test. I also verify, to the best of my knowledge, that all of the information I have provided is correct.

I understand that with insurance this test is provided at no cost to me.

I also understand that my employer/school and the health department may receive my individual results.

I authorize my documents to be emailed for insurance purposes.

SIGNATURE OF PATIENT _____

PRINTED NAME_____ Date ____/_____/2021

SIGNATURE OF PARENT OR LEGAL GUARDIAN IF MINOR PATIENT

_____

PRINTED NAME_____ Date ____/_____/2021

RETURN TO WORK OR SCHOOL

TODAY'S DATE_____CLINIC SITE_____

EMPLOYEE/STUDENT NAME_____

PLACE OF EMPLOYEEMENT/SCHOOL_____

Name of Provider: _____

Date Symptoms Began:_____

- **The employee/student may return to work/school with a full, regular schedule with no restrictions, beginning date: _____**
- **The employee/student is unable to return to work/school until, date: _____**

*Sars Antigen Rapid Testing

*COVID-19		STREP		Flu	
NEGATIVE	POSITIVE	NEGATIVE	POSITIVE	NEGATIVE	POSITIVE

OTHER INSTRUCTION PER PROVIDER _____

_____

_____

Signature of person completing this form

_____

Printed name of person completing this form_____

Date_____Time_____